UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,

Defendants.

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DEFENDANTS' FIRST SET OF INTERROGATORIES AND REQUEST FOR PRODUCTION OF DOCUMENTS TO PLAINTIFFS

17-CV-05221 (KAM) (RLM)

Pursuant to Rules 26, 33, and 34 of the Federal Rules of Civil Procedure and Local Rule 26.3 of this Court, defendants The City of New York and Detective Rudy Anzalone hereby request that each plaintiff serve upon the undersigned sworn written answers to each of the interrogatories set forth below and produce for inspection and copying the documents requested below at the offices of Zachary W. Carter, Corporation Counsel of the City of New York at 100 Church Street, New York, New York 10007, within thirty (30) days after service hereof.

These interrogatories and document requests are continuing. If at any time after service of answers hereto, and prior to the trial of this action, plaintiffs obtain or become aware of additional information pertaining to any of these interrogatories or document requests, the disclosure of which may be required pursuant to Rule 26(e) of the Federal Rules, plaintiffs shall, within seven days, and in no event later than seven days before trial, serve upon the undersigned supplemental sworn written answers setting forth such additional information and documents.

INSTRUCTIONS

1. If the answer to all or any part of an interrogatory is not presently known or available, include a statement to that effect and furnish any information currently known or available and a description of the source of information that was once known or available that could have been used to respond to the interrogatory.

2. If any information or document called for by an interrogatory or document request is withheld by reason of a claim of privilege, state with specificity the information required by Local Rule 26.2.

DEFINITIONS

1. These definitions incorporate by reference the Uniform Definitions in Discovery Requests set forth in Federal Rule 34(a) and Local Rule 26.3.

2. As used herein, the term "Incident" refers to the events described in the complaint.

INTERROGATORIES

1. Identify all persons who witnessed, were present at, or have knowledge of the Incident, including the home and business addresses and telephone numbers of each witness. If you are unable to identify any of the individuals within the meaning of Local Rule 26.3, describe that individual's physical appearance.

2. Identify any and all statements, signed or unsigned, recorded electronically or otherwise, prepared by plaintiffs or any other person that relate to the claims and/or subject matter of this litigation.

3. Identify any and all statements, signed or unsigned, recorded electronically or otherwise, prepared by the City of New York, or its agents, servants and/or employees, that relate to the claims and/or subject matter of this litigation.

4. Identify all injuries claimed by plaintiffs as a result of the Incident and the medical, psychiatric, psychological, and other treatment provided, if any. For each such treatment received, identify the provider who rendered the treatment to plaintiffs. If no treatment was provided for any claimed injury, so state.

5. Identify all economic injuries claimed by plaintiffs as a result of the Incident including, but not limited to, expenditures for medical, psychiatric, or psychological treatment; lost income; property damage; and attorneys fees. Identify the specific amounts claimed for each injury.

6. Identify all of plaintiffs' employers for the past ten (10) years, including the name, telephone number and address of each employer and the dates of each employment.

7. Identify all medical providers including, but not limited to, doctors, hospitals, psychiatrists, psychologists, social workers and other counseling services, who have rendered treatment to the plaintiffs within the past ten (10) years.

8. Have plaintiffs applied for worker's compensation within the past ten (10) years? If so, identify each employer who provided worker's compensation to plaintiffs.

9. Have plaintiffs applied for social security disability benefits within the past ten (10) years? If so, identify each state, city, or other jurisdiction that provided social security disability benefits to plaintiffs.

10. Have plaintiffs applied for Medicare and/or Medicaid within the past ten (10) years? If so, identify each state, city or other jurisdiction that provided Medicare and/or Medicaid to plaintiffs.

11. Have plaintiffs made a claim with any insurance carrier for physical, mental or emotional injuries within the past ten (10) years? If so, identify each claim by date, injury and insurance carrier.

12. Identify all government agencies to whom plaintiffs made complaints regarding the Incident including, but not limited to, the Civilian Complaint Review Board ("CCRB") and the Internal Affairs Bureau ("IAB") of the New York City Police Department.

13. Identify each occasion on which plaintiffs have been arrested other than the Incident that is the subject of this lawsuit, including the date of the arrest, the charges for which the plaintiffs were arrested, and the amount of time that plaintiffs spent incarcerated.

14. Identify each occasion in which plaintiffs have been convicted of a felony or misdemeanor, including the date of the conviction, the charges of which plaintiffs were convicted, and amount of time that plaintiffs spent incarcerated as a result of each conviction.

15. Identify each lawsuit to which plaintiffs have been a party, including the court in which the matter was pending, the docket or index number, and the disposition of the matter.

16. Identify each occasion on which plaintiffs have given testimony or statements regarding the subject of this lawsuit.

17. Identify all treating physicians and other medical providers that plaintiffs intend to call at the time of trial.

18. Identify all experts that plaintiffs expect to call at the time of trial, all correspondence between counsels for plaintiffs and any such experts, any notes taken by any such experts and provide all disclosures required pursuant to Federal Rule 26(a)(2).

19. Identify all documents prepared by plaintiffs, or any other person, that relate to the Incident, claims and subject matter of this litigation.

20. Identify all Freedom of Information Law requests and any responses thereto, made by plaintiffs or by anyone on plaintiffs' behalf, concerning plaintiffs' claims in this litigation.

DOCUMENT REQUESTS

1. Produce all the documents identified in the preceding Interrogatories.

2. Produce all documents regarding the Incident, including documents concerning plaintiffs' arrest and criminal prosecution (if any), the minutes of any Grand Jury proceedings and criminal court transcripts, and any and all other documents concerning the Incident that are in plaintiffs' possession, custody or control.

3. Produce all medical records including, but not limited to, records of doctors, hospitals, psychiatrists, psychologists, social workers, and other counseling services, in plaintiffs' possession, custody, or control for treatment received by plaintiffs since the Incident and for the five years prior to the Incident, including treatment for any injury resulting from the Incident.

4. Produce all photographs and other audio-visual materials documenting the Incident, the scene of the Incident, and all injuries that resulted from the Incident, including injuries to person and property. Defendants request exact duplicates of the original photographs and audio-visual materials.

5. Produce all documentation of damages that plaintiffs allege stem from the Incident, including, but not limited to, expenditures for medical, psychiatric, or psychological treatment; lost income; property damage; and attorneys fees. Documentation includes, but is not

limited to, paid and unpaid bills, original purchase receipts, cancelled checks, charge slips, appraisals, and warranties.

6. Produce copies of all subpoenas served on any party, or any individual or entity, concerning this litigation.

7. Produce all documents received in response to any subpoenas served.

8. Produce all documents that relate to all complaints made by plaintiff to any government agency regarding the incident including, but not limited to, the CCRB and IAB of the New York City Police Department.

9. If the plaintiffs are claiming lost income in this action, produce plaintiffs' federal and state income tax returns since the Incident and for the five years prior to the Incident.

10. Produce: (a) all expert disclosures required pursuant to Federal Rule 26(a)(2); (b) any drafts of any reports or other disclosures required by Fed. R. Civ. P. 26(a)(2); (c) all correspondence between plaintiffs' counsels, or anyone acting for or on behalf of plaintiffs or plaintiffs' counsels, and any experts identified in response to Interrogatory No. 18, including, but not limited to, any documents reflecting any fee agreements and any instructions plaintiffs' counsels have provided to the expert regarding the expert's expected testimony and/or examination of plaintiffs; and (d) any notes taken by any experts identified in response to Interrogatory No. 18 regarding plaintiffs, plaintiffs' counsels, the incident alleged in the complaint, this lawsuit, the expert's expected testimony or the expert's retention by plaintiffs' counsels in this action.

11. Complete and provide the annexed blank authorizations for release of plaintiffs' medical records including, but not limited to, records of doctors, hospitals, psychiatrists, psychologists, social workers and other counseling services for treatment received

by plaintiffs since the Incident and for the five years prior to the Incident, including treatment for any injury resulting from the Incident.[1]

12. Complete and provide the annexed blank authorization for access to plaintiffs' records that may be sealed pursuant to N.Y. C.P.L. §§ 160.50 and 160.55. Note that the authorization for access to plaintiffs' records that may be sealed pursuant to N.Y. C.P.L. §§ 160.50 and 160.55 that is annexed hereto differs from the authorization that may have been provided at the outset of this litigation in that it is not limited to documents pertaining to the arrest and/or prosecution that is the subject of this litigation.

13. Complete and provide the annexed blank authorizations for release of employment records for each of plaintiffs' employers for the past ten (10) years.[2]

14. Complete and provide the annexed blank authorization for the unemployment records, if any, of plaintiffs.

15. Complete and provide the annexed blank authorizations for insurance carriers with whom plaintiffs have made claims within the past ten (10) years.[3]

16. Complete and provide the annexed blank authorization for the records of social security disability benefits, if any, received by plaintiffs.[4]

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[1] The enclosed releases are believed to be HIPAA-compliant. Please note that HHC hospitals require a particular release, a copy of which is enclosed. A separate release must be provided for each provider. Kindly photocopy the releases before execution so plaintiff can provide a separate release for each provider. The attached release for psychotherapy notes must be provided in addition to a HIPAA release for that provider.

[2] A separate release must be provided for each of plaintiff's employers. A single release form is enclosed. Kindly photocopy the release before execution so plaintiff can provide a separate release for each employer.

[3] A separate release must be provided for each insurance carrier. A single release form is enclosed. Kindly photocopy the release before execution so plaintiff can provide a separate release for each insurance carrier.

[4] A separate release must be provided for each jurisdiction. Kindly photocopy the release before execution so plaintiff can provide a separate release for each such jurisdiction.

17. Complete and provide the annexed blank authorization for plaintiffs' Medicare and/or Medicaid records.[5]

18. Complete and provide the annexed blank authorization for plaintiffs' parole records, if plaintiff was on parole when the Incident occurred.

19. Complete and provide the annexed blank authorization for plaintiffs' income tax records.

Dated: New York, New York
December 15, 2017

ZACHARY W. CARTER
Corporation Counsel of the
City of New York
Attorney for Defendants City of New York and Rudy Anzalone
100 Church Street
New York, New York 10007
(212) 356-3535

By: _____
Christopher DeLuca
Assistant Corporation Counsel

To: VIA HAND DELIVERY
The Rameau Law Firm
Amy Rameau, Esq
16 Court Street, Suite 2504
Brooklyn, NY 11241

[5] A separate release must be provided for each jurisdiction. Kindly photocopy the release before execution so plaintiff can provide a separate release for each such jurisdiction.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

17-CV-05221 (KAM) (RLM)

TO: _____
NAME AND ADDRESS OF MEDICAL PROVIDER

I authorize the use and disclosure of RAYMOND TAVARES'S health information as described below.

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire medical or hospital record of RAYMOND TAVARES (Date of Birth:_____; SS #:_____) who was examined or treated in your hospital or by you on or about_____.

The medical record authorized for release includes any and all x-rays of said person and any and all diagnostic tests, studies, or reports of examinations relating to such person.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol, and drug abuse.

This information may be disclosed to and used by the following organization:
The Office of the Corporation Counsel
100 Church Street
New York, NY 10007
for the purpose of defense of civil litigation

I understand I have the right to revoke this authorization at any time. In understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. Unless otherwise revoked, this

authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorization the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Name of Medical Provider's Risk Management Office).

Dated: New York, New York
_____, 2017

_____
RAYMOND TAVARES

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared RAYMOND TAVARES, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

HHC

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED: Information Requested_____ Treatment Dates from_____ to_____
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request.** ☐ Alcohol and/or Substance Abuse Program Information ☐ Mental Health Information ☐ Genetic Testing Information ☐ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION ☐ Legal Matter ☐ Individual's Request ☐ Other (please specify):_____	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☐ Event:_____ ☐ On this date:_____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE**, **GENETIC TESTING**, **MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9. (a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information: ☐At request of individual ☐Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

17-CV-05221 (KAM)
(RLM)

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants

----------x

RELEASE FOR PSYCHOTHERAPY NOTES

TO: _____ [Health Care Provider]
_____ [Address]
_____ [City, State, Zip]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, YOU ARE HEREBY AUTHORIZED AND DIRECTED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a certified copy of all psychotherapy notes of RAYMOND TAVARES (Date of Birth: _____; SS #: _____) who was examined or treated in your hospital or by you on or about _____.

The reason for this release of information is (a) at the request of individual, or (b) _____. This authorization will terminate upon the resolution of my lawsuit. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to Zachary W. Carter, except to the extent that the provider listed above has taken action in reliance on this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Dated: New York, New York
_____, 2017

_____
RAYMOND TAVARES

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared RAYMOND TAVARES, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

DESIGNATION OF AGENT FOR ACCESS TO RECORDS SEALED PURSUANT TO NYCPL §§ 160.50 AND 160.55

I, Raymond Tavares, Date of Birth _____, SS# _____, NYSID # _____ pursuant to CPL §§ 160.50 and 160.55, hereby designate ZACHARY W. CARTER, Corporation Counsel of the City of New York, or his authorized representative, as my agent to whom all records of any of my arrests may be made available.

I understand that until now the aforesaid records have been sealed pursuant to CPL §§ 160.50 and 160.55, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of CPL § 160.50 and 160.55.

The records to be made available to the person designated above comprise all records and papers relating to any and all of my arrests on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of CPL §§ 160.50 and 160.55.

_____
Signature

_____
Raymond Tavares

STATE OF NEW YORK)
: SS.:
COUNTY OF)

On the _____ day of _____, 2017, before me personally came _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and he acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

RELEASE FOR EMPLOYMENT RECORDS

17-CV-05221 (KAM) (RLM)

TO: _____
NAME AND ADDRESS OF EMPLOYER

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire employment record, including but not limited to the application, attendance records, disciplinary records, performance evaluations, workers' compensation records, medical records/nurses records, and/or any doctors notes, and psychiatric/psychological records of RAYMOND TAVARES (Date of Birth:_____; SS #:_____), employed by you from _____ until _____.

Dated: New York, New York
_____, 2017

_____
RAYMOND TAVARES

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared RAYMOND TAVARES, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

UNEMPLOYMENT RECORDS RELEASE

17-CV-05221 (KAM) (RLM)

TO: DEPARTMENT OF LABOR

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of RAYMOND TAVARES (Date of Birth:_____; SS #:_____), who received unemployment benefits from _____ to _____.

The unemployment file authorized for release includes, but is not limited to, any and all applications, determinations, correspondence, payments or credits made to such person.

The information is sought for the purpose of _____ and will be used solely for this purpose.

Dated: New York, New York
_____, 2017

_____
RAYMOND TAVARES

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared RAYMOND TAVARES, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants

----------x

MEDICARE RECORDS RELEASE

17-CV-05221 (KAM) (RLM)

TO: FOIA Service Center/FOIA Public Liaison
Centers for Medicare Services
26 Federal Plaza
New York, NY 10278

YOU ARE HEREBY AUTHORIZED and I hereby request you to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of RAYMOND TAVARES (Date of Birth:_____; SS #:_____), who received Medicare benefits from _____ to _____.

The Medicare file authorized for release includes, but is not limited to, any and all applications, determinations, correspondence, payments or credits made to such person.

This Authorization will expire at the conclusion of the above-captioned litigation.

I understand that I have the right to revoke this authorization at any time. I must do so by writing to the same person(s) or class of persons that I directed this authorization to. The revocation will not apply to information that has already been released in response to this authorization.

I understand that my refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by law.

Dated: New York, New York
_____, 2017

_____
RAYMOND TAVARES

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared RAYMOND TAVARES, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

RELEASE FOR INSURANCE CARRIER RECORDS

17-CV-05221 (KAM) (RLM)

TO: _____
NAME AND ADDRESS OF INSURANCE CARRIER

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of RAYMOND TAVARES (Date of Birth:_____; SS #:_____), who received benefits from your insurance company.

The insurance carrier file authorized for release includes, but is not limited to, any and all applications, description of injuries, determinations, correspondence, payments or credits and all documents relating to such person's claim for insurance benefits.

Dated: New York, New York
_____, 2017

_____
RAYMOND TAVARES

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared RAYMOND TAVARES, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

AUTHORIZATION FOR STATE OF NEW YORK DIVISION OF PAROLE RECORDS

17-CV-05221 (KAM) (RLM)

TO: STATE OF NEW YORK, DIVISION OF PAROLE

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendant(s) in the above-captioned case, or to his authorized representative, **CERTIFIED COPIES** of all records, created by, or in the possession of, the State of New York Division of Parole for RAYMOND TAVARES (Date of Birth:_____ SS #: _____).

Dated: New York, New York
_____, 2017

_____
RAYMOND TAVARES

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared RAYMOND TAVARES, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

17-CV-05221 (KAM) (RLM)

TO: _____
NAME AND ADDRESS OF MEDICAL PROVIDER

I authorize the use and disclosure of TITO KEE'S health information as described below.

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire medical or hospital record of TITO KEE (Date of Birth:_____; SS #:_____) who was examined or treated in your hospital or by you on or about_____.

The medical record authorized for release includes any and all x-rays of said person and any and all diagnostic tests, studies, or reports of examinations relating to such person.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol, and drug abuse.

This information may be disclosed to and used by the following organization:
The Office of the Corporation Counsel
100 Church Street
New York, NY 10007
for the purpose of defense of civil litigation

I understand I have the right to revoke this authorization at any time. In understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. Unless otherwise revoked, this

authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorization the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Name of Medical Provider's Risk Management Office).

Dated: New York, New York
_____, 2017

_____
TITO KEE

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared TITO KEE, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

HHC

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED: Information Requested_____ Treatment Dates from_____ to_____
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request.** ☐ Alcohol and/or Substance Abuse Program Information ☐ Mental Health Information ☐ Genetic Testing Information ☐ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION ☐ Legal Matter ☐ Individual's Request ☐ Other (please specify):_____	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☐ Event:_____ ☐ On this date:_____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE**, **GENETIC TESTING**, **MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

14. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

15. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

16. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

17. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

18. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

19. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

20. Name and address of health provider or entity to release this information:

21. Name and address of person(s) or category of person to whom this information will be sent:

22. (a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

23. Reason for release of information: ☐ At request of individual ☐ Other:	24. Date or event on which this authorization will expire:
25. If not the patient, name of person signing form:	26. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

17-CV-05221 (KAM)
(RLM)

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

RELEASE FOR PSYCHOTHERAPY NOTES

TO: _____ [Health Care Provider]
_____ [Address]
_____ [City, State, Zip]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, YOU ARE HEREBY AUTHORIZED AND DIRECTED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a certified copy of all psychotherapy notes of TITO KEE (Date of Birth: _____; SS #: _____) who was examined or treated in your hospital or by you on or about _____.

The reason for this release of information is (a) at the request of individual, or (b) _____. This authorization will terminate upon the resolution of my lawsuit. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to Zachary W. Carter, except to the extent that the provider listed above has taken action in reliance on this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Dated: New York, New York
_____, 2017

_____
TITO KEE

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared TITO KEE, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

DESIGNATION OF AGENT FOR ACCESS TO RECORDS SEALED PURSUANT TO NYCPL §§ 160.50 AND 160.55

I, Tito Kee, Date of Birth _____, SS# _____, NYSID # _____ pursuant to CPL §§ 160.50 and 160.55, hereby designate ZACHARY W. CARTER, Corporation Counsel of the City of New York, or his authorized representative, as my agent to whom all records of any of my arrests may be made available.

I understand that until now the aforesaid records have been sealed pursuant to CPL §§ 160.50 and 160.55, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of CPL § 160.50 and 160.55.

The records to be made available to the person designated above comprise all records and papers relating to any and all of my arrests on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of CPL §§ 160.50 and 160.55.

_____
Signature

_____
Tito Kee

STATE OF NEW YORK)
: SS.:
COUNTY OF)

On the _____ day of _____, 2017, before me personally came _____, to me known and known to me to be the individual described in and who executed the foregoing instrument, and he acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

RELEASE FOR EMPLOYMENT RECORDS

17-CV-05221 (KAM) (RLM)

TO: _____
NAME AND ADDRESS OF EMPLOYER

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire employment record, including but not limited to the application, attendance records, disciplinary records, performance evaluations, workers' compensation records, medical records/nurses records, and/or any doctors notes, and psychiatric/psychological records of TITO KEE (Date of Birth:_____; SS #:_____), employed by you from _____ until _____.

Dated: New York, New York
_____, 2017

_____
TITO KEE

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared TITO KEE, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

UNEMPLOYMENT RECORDS RELEASE

17-CV-05221 (KAM) (RLM)

TO: DEPARTMENT OF LABOR

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of TITO KEE (Date of Birth:_____; SS #:_____), who received unemployment benefits from _____ to _____.

The unemployment file authorized for release includes, but is not limited to, any and all applications, determinations, correspondence, payments or credits made to such person.

The information is sought for the purpose of _____ and will be used solely for this purpose.

Dated: New York, New York
_____, 2017

_____
TITO KEE

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared TITO KEE, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants

----------x

MEDICARE RECORDS RELEASE

17-CV-05221 (KAM) (RLM)

TO: FOIA Service Center/FOIA Public Liaison
Centers for Medicare Services
26 Federal Plaza
New York, NY 10278

YOU ARE HEREBY AUTHORIZED and I hereby request you to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of TITO KEE (Date of Birth:_____; SS #:_____), who received Medicare benefits from _____ to _____.

The Medicare file authorized for release includes, but is not limited to, any and all applications, determinations, correspondence, payments or credits made to such person.

This Authorization will expire at the conclusion of the above-captioned litigation.

I understand that I have the right to revoke this authorization at any time. I must do so by writing to the same person(s) or class of persons that I directed this authorization to. The revocation will not apply to information that has already been released in response to this authorization.

I understand that my refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by law.

Dated: New York, New York
_____, 2017

_____
TITO KEE

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared TITO KEE, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

RELEASE FOR INSURANCE CARRIER RECORDS

17-CV-05221 (KAM) (RLM)

TO: _____
NAME AND ADDRESS OF INSURANCE CARRIER

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of TITO KEE (Date of Birth:_____; SS #:_____), who received benefits from your insurance company.

The insurance carrier file authorized for release includes, but is not limited to, any and all applications, description of injuries, determinations, correspondence, payments or credits and all documents relating to such person's claim for insurance benefits.

Dated: New York, New York
_____, 2017

_____
TITO KEE

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared TITO KEE, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

RAYMOND TAVARES AND TITO KEE,

Plaintiffs,

-against-

THE CITY OF NEW YORK, Detective RUDY ANZALONE, Shield No. 5617, Police Officer JOHN DOE ONE through TEN in their individual and official capacities as employees of the City of New York,,

Defendants
----------x

AUTHORIZATION FOR STATE OF NEW YORK DIVISION OF PAROLE RECORDS

17-CV-05221 (KAM) (RLM)

TO: STATE OF NEW YORK, DIVISION OF PAROLE

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendant(s) in the above-captioned case, or to his authorized representative, **CERTIFIED COPIES** of all records, created by, or in the possession of, the State of New York Division of Parole for TITO KEE (Date of Birth:_____ SS #: _____).

Dated: New York, New York
_____, 2017

_____
TITO KEE

STATE OF NEW YORK)
: SS:
COUNTY OF _____)

On the _____ day of _____, 2017, before me personally came and appeared TITO KEE, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

_____
NOTARY PUBLIC